New Jersey Department of Health and Senior Services
Maternal, Child and Community Health - Primary Care Office
PO Box 364
Trenton, NJ 08625-0364

J-1 VISA WAIVER PHYSICIAN-PRIMARY CARE SURVEY
INITIAL/BIANNUAL SERVICE REPORT

1. Name of Agency	
2. Address	
3. Telephone Number	4. Name of Executive Director
5. Period Cover	

This will certify that _____ MD, provided comprehensive primary care services to patients at the approved health facility site on a full time basis (minimum 40 hours/week) for the time period covered in this report with the exceptions (illness, vacation, CME program, etc.) specified below:

Inclusive Dates	**Reasons**

6.

Type of Site Providers:	**Number**	**Total Hours/ Week***	**Biannual Visits**
Family/General Practice			
Internal Medicine			
Pediatrics			
Obstetrics/Gynecology			
Dental (specify type)			
_____			
Certified Nurse Midwife			
Nurse Practitioner			
Other:			
_____			
_____			

*For example, if there are two providers working 20 hours and 40 hours/week respectively, the cumulative total would be 60 hours/week.

7. Hours of Operation and Days Per Week:

Monday	_____	Wednesday	_____	Friday	_____
Tuesday	_____	Thursday	_____	Saturday	_____

8. Primary Service Area(s) (by city/township/borough/county):

_____

INITIAL/BIANNUAL SERVICE REPORT, Continued

Name of Agency

9. Client Population:

(In each category list the number of **unduplicated** clients and the number of biannual encounters for the reporting period):

	Number of Clients	Number of Visits
Medicare **		
Medicaid **		
Sliding Fee Scale:		
Self Pay		
Uninsured		
Commercial Insurance		
Other (Specify):		
_____		
Total:		

**Include those enrolled in managed care organizations.

10. Children and Adolescents (0-21) _____

11. For this J-1 Visa Provider _____

12. Income Source (as a percent of total revenue)

Medicare	%
Medicaid	%
Sliding Fee Scale:	
Self Pay	%
Uninsured	%
Commercial Insurance	%
Other (Specify):	
_____	%
Total	%

13. Do you accept new clients regardless of insurance type?

☐ Yes ☐ No

a. If not, which of the above insurance groups are not accepted?

_____

14. Cost Per Encounter: $ _____ (Divide total revenue by biannual encounters)

Name of Person Completing the Survey (Print)	Telephone Number ( )
Title	
Signature	Date

Your cooperation is greatly appreciated!
Please retain a copy of the survey and return the original to the address at the top of Page 1